

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 231

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Landonville Hills</u> LENGTH OF STAY (In this place) <u>5 years</u> TOWN <u>Landonville Hills</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4106 - 70<sup>th</sup> Ave</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Pr. Georges</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Landonville Hills</u> TOWN <u>Landonville Hills</u> STREET ADDRESS (If rural, give location) <u>4106 - 70<sup>th</sup> Ave</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>John</u> (Middle) <u>Arcella</u> (Last) <u>Arcella</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>1</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec - 21, 1872</u> 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Operator</u>	9. AGE last birthday <u>78</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY No. <u>577-38-1371</u>	
17. INFORMANT AND ADDRESS <u>Elizabeth Arcella - Wife</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Acute congestive heart failure</u>			
Antecedent cause(s) (b) <u>Tuberculosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Broncho-pneumonia</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>John W. Maloney, M.D., Dep. Med. Exam.</u>		DATE SIGNED <u>Feb 2-4-57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2/5/57</u>	
NAME OF CEMETERY OR CREMATORY <u>Lincoln Cemetery</u>		LOCATION (City, town, or county) (State) <u>Calmar Manor Md.</u>	
DATE REC'D BY LOCAL REG. <u>2/5/57</u>		REGISTRAR'S SIGNATURE <u>Wanda Doney</u>	
24. FUNERAL DIRECTOR <u>E. Gasche Sons</u>		ADDRESS <u>Hyattsville Md.</u>	

MARGIN RESERVED FOR BINDING

VS-A15A



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH COUNTY <u>PRINCE GEORGE'S</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>D.C.</u> COUNTY <u>None</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>DEAT PLEASANT</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
TOWN <u>CHICK SANITARIUM</u>		TOWN <u>WASHINGTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CHICK SANITARIUM</u>		STREET ADDRESS (If rural, give location) <u>1612 - E. ST. N.E.</u>	
3. NAME OF DECEASED (Type or Print) <u>ELSIE</u> (First) <u>(NMN)</u> (Middle) <u>ATKINSON</u> (Last)		4. DATE OF DEATH <u>FEB. 14</u> (Month) <u>14</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>DIVORCED</u>	8. DATE OF BIRTH <u>OCT. 29, 1869</u>
9. AGE last birthday <u>81</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>?</u>	14. MOTHER'S MAIDEN NAME <u>Unknown</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service) <u>None</u>	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Mrs. Margaret Cain</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Cerebral thrombosis</u>	<u>about 5 days</u>
Antecedent cause(s)	(b) <u>Cerebral arterio-sclerosis</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Generalized arterio-sclerosis</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arterio-sclerotic heart disease.</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Jun 3</u> , 19 <u>51</u> , to <u>Feb. 14</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Feb. 13</u> , 19 <u>51</u> , and that death occurred at <u>3 a</u> m., from the causes and on the date stated above.		
SIGNATURE <u>Walter K. Angerine, M.D.</u>		DATE SIGNED <u>2/14/51</u>
ADDRESS <u>6300 - 13<sup>th</sup> St. N.W.</u>		
23. BURIAL CREMATION REMOVAL (Specify)	DATE <u>Feb. 16, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>
LOCATION (City, town, or county) <u>Scitland, Maryland</u>	(State) <u>Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 15, 1951</u>	REGISTRAR'S SIGNATURE <u>Carrie S. Campbell</u>	24. FUNERAL DIRECTOR <u>W.W. Chambers Co., 517 11<sup>th</sup> St. S.E.</u>
ADDRESS <u>Wash., D.C.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Hand  
del.

RECEIVED  
FEB 19 1951  
BUREAU F. B. I.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH: COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md</u> COUNTY <u>P. G.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>105 7th St</u>	
3. NAME OF DECEASED (Type or Print) <u>William (First) Joseph (Middle) Barnes (Last)</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 26 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 13, 1874</u> 76 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer (General)</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>General Work</u>	
10. FATHER'S NAME <u>Joseph Bonds Barnes</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		13. SOCIAL SECURITY No. <u>None</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Jones</u>		15. INFORMANT AND ADDRESS <u>Edna Bonds 105 7th St Laurel Md</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) <u>Hypertension Heart Disease</u>		
(b) <u>Hypertension Chronic Myocarditis</u>		
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg. etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/6, 1950, to 2/26, 1951, that I last saw the deceased alive on 2/25, 1950, and that death occurred at 2 p m., from the causes and on the date stated above.

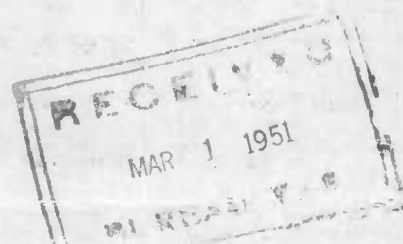
SIGNATURE W B Barnes ADDRESS Laurel Md DATE SIGNED 5/27/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Feb 28 1951</u>	<u>Long Hill</u>	<u>Laurel Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Feb 27 - 51</u>	<u>M. Brashers</u>	<u>Ridgley Selby</u>	<u>401 Wash. Ave 976 VV Laurel Md.</u>

MARGIN RESERVED FOR BINDING

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VS. A15



Evidence for addition of MARYLAND STATE DEPARTMENT OF HEALTH  
5,6,7,8,9., shown on:

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 243

FILE No. G 131 MAR 7 1951

1. PLACE OF DEATH: COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale, Md.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN District of Columbia	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Tuberculosis. San.		STREET ADDRESS 1607 17th Street Northwest	
3. NAME OF DECEASED (Type or Print) EDWARD BARRETT		4. DATE OF DEATH (Month) 2 (Day) 26 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 5/18/91
9. AGE last birthday 38 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthony Barrett		14. MOTHER'S MAIDEN NAME Ida Thorpe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 327-11-1702	
17. INFORMANT AND ADDRESS Decedent			

## 18. MEDICAL CERTIFICATION

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

#### Immediate cause

(a) tuberculous meningitis

INTERVAL BETWEEN ONSET AND DEATH

32 days

#### Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) pulmonary tuberculosis

1 1/2 yrs.

### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 12-17, 1950, to 2-26, 1951, that I last saw the deceased alive on 2-26, 1951, and that death occurred at 6:05 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION  
REMOVAL (Specify)

DATE THEREOF  
3/1/51

NAME OF CEMETERY OR CREMATORY  
Washington National Cemetery

LOCATION (City, town, or county)  
Glenn Dale, Md.

(State)

DATE REC'D BY LOCAL  
REG. 2/27/51

REGISTRAR'S SIGNATURE  
W. W. W.

24. FUNERAL DIRECTOR  
Robert A. Mattingly

ADDRESS

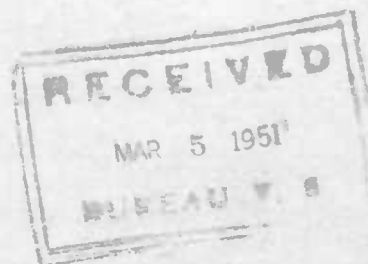
490VVV 181-11 St. S. E. Wash. D.C.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.







# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1736 *2/5*

1. PLACE OF DEATH COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Pr. Geo.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Rainier</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Rainier</i>	
TOWN <i>Mt. Rainier</i>		TOWN <i>Mt. Rainier</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <i>3501-Berry Street</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>John</i>	(Middle) <i>H</i>	(Last) <i>Beall</i>
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>1/28/1876</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Insurance Agent</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Metropolitan Ins.</i>	11. BIRTHPLACE (State or foreign country) <i>Prince Georges Co Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Wm Thomas Beall</i>	14. MOTHER'S MAIDEN NAME <i>Kennetta E. Hardy</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT <i>Lillian Brown Beall, (Wife)</i>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443x Immediate cause (a) *Cardiac Tamponade - Ruptured Dissecting Aneurysm into Pericardium* 2 1/2 Minutes  
Antecedent cause(s) (b) *Dissecting Aneurysm 1-2-45 (Ruptured 2-9-50)* 6+ yrs  
30d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) *3 Smaller Dissecting Aneurysms*  
*Hypertensive Cardiovascular Disease* 10 yrs

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. *Polyps in Colon, Rectal Hemorrhage*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
HOMICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
OF INJURY	m.	

22. I hereby certify that I attended the deceased from *1-2*, 1945, to *2-9*, 1951, that I last saw the deceased

alive on *2-5*, 1951, and that death occurred at *3:00 A.M.*, from the causes and on the date stated above.

SIGNATURE *W.B. Meyer M.D.* ADDRESS *Mt. Rainier Md* DATE SIGNED *2-9-51*

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>2/12/1951</i>	NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>	LOCATION (City, town, or county) <i>Calmar Manor, Pr. Geo. Md</i>	(State)
DATE REC'D BY LOCAL REG. <i>FEB 11, 1951</i>	REGISTRAR'S SIGNATURE <i>JAMES SEVY</i>	24. FUNERAL DIRECTOR <i>Nalley's Funeral Home</i>	ADDRESS <i>3200-R.I. Ave. 450736 Mt. Rainier, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 14 1951  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

### FOR MEDICAL EXAMINERS

Reg. Dist. No. 231

1. PLACE OF DEATH - COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>P. Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Columbia Park - Landover</u>	
TOWN <u>Chesley</u>		TOWN <u>Columbia Park - Landover</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges General Hosp</u>		STREET ADDRESS <u>—</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Benjamin</u> (Middle) <u>Franklin</u> (Last) <u>Bean</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>18</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1-18-31</u>
9. AGE last birthday <u>20</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Production work</u>	
11. BIRTHPLACE (State or foreign country) <u>Chesley Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles H. Bean</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Waldron</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>578-407935</u>	
17. INFORMANT AND ADDRESS <u>Charles H Bean Landover Md</u>			

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

819.5 Immediate cause (a) Hemorrhage & shock

1700

Antecedent cause(s)

(b) Fractured skull & crushed chest(c) Automobile accident

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office, etc.) OF INJURY Street

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY 2-18-51 9:30 P.M.INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Passenger in automobile struck by which lost contact and hit a telephone pole.

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

RECEIVED  
FEB 21 1951  
BUREAU A.M.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *245*

1. PLACE OF DEATH COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Prince George</i>	
CITY (If outside corporate limits, write RURAL and OR TOWN <i>Mt Kainer Md</i> )		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Mt Kainer, Md</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <i>4505 - 30th street</i>	
3. NAME OF DECEASED (Type or Print) (First) <i>ANNIE</i> (Middle) (Last) <i>BECK</i>		4. DATE OF DEATH (Month) <i>Feb</i> (Day) <i>28</i> (Year) <i>51</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>9/6/1866</i>
9. AGE last birthday <i>84</i> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Moses Heagy</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT AND ADDRESS <i>Thelen C Colon Mt Kainer Md</i>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause  
94a Antecedent cause(s)  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) *Coccal Thrombosis*  
(b) *Hypertension*  
(c)

INTERVAL BETWEEN ONSET AND DEATH

*2/23/51*

#### II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *5-2*, 19*50*, to *2-23*, 19*51*, that I last saw the deceased alive on *2-23*, 19*51*, and that death occurred at *9:35* p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*George Heagy 3717-38th Ave. Annapolis, Md 2/24/51*  
*Funeral Home*  
*Feb 24 1951*  
*James Sevey*  
*L. Seachase Hyattsville Md*

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 275

1. PLACE OF DEATH: COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write nearest town) <u>Chillum Terrace</u>		CITY (If outside corporate limits, write nearest town) <u>Chillum Terrace</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>817 Sheridan St.</u>	
3. NAME OF DECEASED (First) <u>SARAH</u> (Middle) <u>BIRCH</u> (Last) <u>BIRCH</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>24</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 13, 1866</u>
9. AGE last birthday <u>84</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Tenn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Wanner</u>		14. MOTHER'S MAIDEN NAME <u>Lane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>George H. Birch</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 Immediate cause

(a) arteriosclerotic Heart Disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

93d

(b) arteriosclerosis

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1946, to Feb, 1957, that I last saw the deceasedalive on 24 Feb, 1957, and that death occurred at 2:10 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15



RECEIVED  
FEB 27 1951  
U. S. DEPT. OF JUSTICE

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH: COUNTY <u>Pr George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Pr. Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Avondale</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Avondale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>4803 - LaSalle Rd.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last) <u>Harriett M. Bishop</u>		(Month) (Day) (Year) <u>Feb. 26th 1951</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 23. 03</u>
9. AGE last birthday <u>48</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H.W.</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>	
13. FATHER'S NAME <u>Elmore S. Staples</u>		14. MOTHER'S MAIDEN NAME <u>Ella H. Staples</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT <u>Earl C. Bishop</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

## Immediate cause

(a)

Mutastatic Carcinoma

## Antecedent cause(s)

(b)

Carcinoma Urinary Bladder

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 20, 1950, to Feb 26, 1951, that I last saw the deceasedalive on Feb 20, 1951, and that death occurred at 9 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

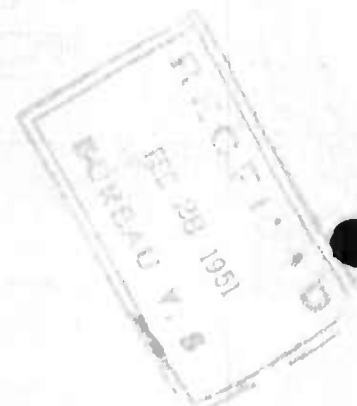
24. FUNERAL DIRECTOR

ADDRESS

Feb 26 1951Wm. Jas. Severe (Deputy)Wm. Lee Sons Co - 306 - 4th St. N.E.1801 K St. N.W. Wash 6, D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince George's</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Chesley</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George's General</u>		STREET ADDRESS (If rural, give location) <u>Mounts Cott Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Frank</u> (First)	<u>A</u> (Middle)	<u>Boteler</u> (Last)	4. DATE OF DEATH <u>Feb 6</u> (Month) (Day) (Year) <u>1951</u>
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>m</u>	8. DATE OF BIRTH <u>Apr 24 1866</u> (Month) (Day) (Year)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE last birthday <u>84</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. FATHER'S NAME <u>Amos Boteler</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. MOTHER'S MAIDEN NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>?</u>	
17. INFORMANT AND ADDRESS <u>James Boteler - Berwyn Md</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) <u>420.0 Immediate cause Hypostatic Pneumonia</u>			
(b) <u>137.2 Antecedent cause(s) Stroke Adam Syndrome</u>			
(c) <u>Anterisclerotic heart disease</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Prostatic Hypertrophy</u>			
19a. DATE OF OPERATION <u>2-5-51</u>	19b. MAJOR FINDINGS OF OPERATION <u>Hydronephrosis cystostomy</u>	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>—</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>—</u>	(CITY OR TOWN) <u>—</u>	(COUNTY) <u>—</u> (STATE) <u>—</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>—</u>	
22. I hereby certify that I attended the deceased from <u>1-1</u> 19 <u>51</u> , to <u>2/6</u> 19 <u>51</u> , that I last saw the deceased alive on <u>2/5</u> 19 <u>51</u> , and that death occurred at <u>3:30 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Edw. Etienne M.D.</u>		ADDRESS <u>College Park Md</u> DATE SIGNED <u>2/7/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/9/51</u>	NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
DATE REC'D BY LOCAL REG. <u>8 Feb 1951</u>	REGISTRAR'S SIGNATURE <u>Amanda Doney</u>	24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville Maryland.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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FEB 13 1951  
DEAU P. B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH: COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>P. Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chesley</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt. Rainier</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Geo. Gen. Hosp.</u>		STREET ADDRESS (If rural, give location) <u>3714-35th Street</u>	
3. NAME OF DECEASED (Type or Print) <u>ELVIN F. BLANCHARD</u>		4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>9</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept. 31, 1901</u>
9. AGE last birthday <u>49</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Augustus H. Blanchard</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mc. Connell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS (wife) <u>Gertrude Blanchard, 3714-35th St.</u>			

### 18. MEDICAL CERTIFICATION

#### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Acute congestive heart failure  
(b) Crushed chest  
(c) Multiple fractures of extremities

INTERVAL BETWEEN ONSET AND DEATH

#### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☒ No ☐

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY 1-27-51 7:02 P.M.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

Struck by automobile while crossing street

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

#### 23. BURIAL, CREMATION REMOVAL (Specify)

#### DATE THEREOF

#### NAME OF CEMETERY OR CREMATORY

#### LOCATION (City, town, or county)

(State)

#### DATE REC'D BY LOCAL REG.

#### REGISTRAR'S SIGNATURE

#### 24. FUNERAL DIRECTOR

#### ADDRESS

2/11/51

Amanda Dourney

Nolley's Funeral Home, 3200 R.I. Ave.

Mt. Rainier, Md 390916

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH - COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>FLORIDA</u> COUNTY <u>DUVAL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>MYRTLE VILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>JACKSONVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4302 KENNEDY ST.</u>		STREET ADDRESS (If rural, give location) <u>1302 HOLLYWOOD AVE.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>MAUDE</u> (Middle) <u>IRENE</u> (Last) <u>BRADBURN</u>	4. DATE OF DEATH	(Month) <u>2</u> (Day) <u>22</u> (Year) <u>1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WID.</u>	8. DATE OF BIRTH <u>1-20-82</u>
			9. AGE last birthday <u>69</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. TREASURY</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MAURICE E. SHIPLEY</u>		14. MOTHER'S MAIDEN NAME <u>ELLA E. PYWELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
		17. INFORMANT AND ADDRESS <u>Walter K. Shipley, 901 Channing St. N.E., Washington, D.C.</u>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of Cervix

INTERVAL BETWEEN ONSET AND DEATH 1 year

Antecedent cause(s)

(b) metastasis to bladder

1 month

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. none

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1-22, 1951, to 2-22, 1951, that I last saw the deceased

alive on 2-22, 1951, and that death occurred at 10:45 A.M., from the causes and on the date stated above.

SIGNATURE R. B. Bamer

(Degree or title) M.D.

ADDRESS 4314 Cassin St.

DATE SIGNED 2-22-51

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF <u>2-26-51</u>	NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM.</u>	LOCATION (City, town, or county) <u>PRINCE GEORGE CO. MD.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <u>James Severy</u>	24. FUNERAL DIRECTOR <u>W. H. Hines Co., Washington, D.C.</u>	ADDRESS <u>3969 16</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED BY THE UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C. 20250

CERTIFICATE OF ANALYSIS

RECEIVED  
FEB 26 1951  
BUREAU OF AGRICULTURE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Prince George  
 City or town Hillside  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 hr 4 mos  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince George  
 City or town Hillside  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1408-57th Ave  
 (If rural, give LOCATION)  
 2(a) If veteran, name war —

## 3. (a) FULL NAME

Mary Elizabeth Bresnahan

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Ernest P. Bresnahan

7. Birth date of deceased (mo., day, yr.) May 23, 1880

8. AGE: Years 70 Months — Days — If less than one day — hrs. — min. —

9. Birthplace Wash. D.C.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

12. Name Charles W. Smith

13. Birthplace D.C.

14. Maiden name Angela Ann Smith

15. Birthplace D.C.

16. Informant Mrs. Dorothea C. Thornton

Address 1408-57th Ave Hillside Md

17. (Burial, cremation, or removal. Which?) Mar 3, 1951  
 Date thereof (month) (day) (year)

Cemetery or crematory St. X Oline's

Location Washington D.C.

18. Funeral director John A. Matthews

Address 131-112th St Wash DC

19. 2-28 19 51  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 19 51 at 445 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 22 19 51 to Feb 27 19 51

and that I last saw her alive on Feb 26 19 51

Immediate cause of death acute congestive heart failure

DURATION 24 hr

Due to Cerebral Hemorrhage

Paralysis of right side of body

Due to general arteriosclerosis

Other conditions none of note

Major findings of operations 331X  
93d

(Include pregnancy within 3 months of death)

Antopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide natural cause

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Injured at work?

Means of injury

23. SIGNATURE Robert J. Smith M. D.

Address Washington 19 DC Date signed Feb 27 19 51

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 230

1745

1. PLACE OF DEATH COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>PR. GEO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>GREENBELT</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>GREENBELT</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2A-RESEARCH RD</u>		STREET ADDRESS (If rural, give location) <u>2A-RESEARCH ROAD</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>THOMAS</u>	(Middle) <u>FRANCIS</u>	(Last) <u>BURKE</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>10/19/1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OF STORE (GROCERY)</u>	9. AGE last birthday <u>61</u> yrs.
13. FATHER'S NAME <u>PATRICK BURKE</u>		14. MOTHER'S MAIDEN NAME <u>ROSE HARRIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>187-09 5355</u>	
17. INFORMANT AND ADDRESS <u>KATHERINE M. BURKE - 2A-RESEARCH RD</u>		<u>GREENBELT MD</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
Immediate cause (a) <u>Respiratory Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6-8 hours</u>	
420.1 Antecedent cause(s) (b) <u>Coronary Thrombosis</u>		24 hours	
940 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Generalized Arterio-sclerosis</u>		years	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from November, 1950, to Feb. 3, 1951, that I last saw the deceased alive on Feb. 3, 1951, and that death occurred at 5:15 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) William M. Eisner M.D. ADDRESS 30 B. Ridge Rd. Greenbelt Md DATE SIGNED 2-4-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>FEB 4/1951</u>	NAME OF CEMETERY OR CREMATORY <u>MOUNTAIN VIEW CEMETERY</u>	LOCATION (City, town, or county) (State) <u>WEST HAZELTON, PENNA.</u>
DATE REC'D BY LOCAL REG. <u>Feb 4-1951</u>	REGISTRAR'S SIGNATURE <u>John D. Smith</u>	24. FUNERAL DIRECTOR <u>W.W. CHAMBERS Co - RIVERDALE, MD.</u>	

770636

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
FEB 8 1951  
BUREAU T. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *246*

1746

1. PLACE OF DEATH- COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Prince Geo Bty</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Pk.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>X X X</i>		STREET ADDRESS (If rural, give location) <i>7107-13<sup>th</sup> ave.</i>	
3. NAME OF DECEASED (Type or Print) <i>CAMILLA MARIE CAMERON</i>		4. DATE OF DEATH (Month) <i>Feb.</i> (Day) <i>16</i> (Year) <i>1951</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Oct 12, 1866</i>
9. AGE last birthday <i>84</i> yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Norway</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Martinus Ager</i>		14. MOTHER'S MAIDEN NAME <i>Mathea Stelansen</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none.</i>	
17. INFORMANT AND ADDRESS <i>Mrs Hanna Sylvesten</i>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) *Hepatic cirrhosis, portal.*

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

*1 yr.*

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July 27*, 1937, to *Feb. 16*, 1951, that I last saw the deceasedalive on *Jan. 29*, 1951, and that death occurred at *6:30 a.* m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*W.G. Meerman, M.D.**10616 Lorain Ave, Silver Spring Md. Feb. 16, 1951.*

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*Jan 16 1951 James Severy**H.H. Chambers Co 1400 Chapin St*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED  
FEB 19 1951  
IN REPLY



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1747 234

1. PLACE OF DEATH COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Prince Geo.	
CITY (If outside corporate limits, write RURAL and give nearest town) Accokeek		CITY (If outside corporate limits, write RURAL and give nearest town) Accokeek	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) Homer	(Middle) C	(Last) Cder	4. DATE OF DEATH (Month) Feb. (Day) 4 (Year) 1957
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, <u>DIVORCED</u> , (Specify)	8. DATE OF BIRTH Not known
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Driver.	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 70 yrs.	11. BIRTHPLACE (State or foreign country) Not known
13. FATHER'S NAME Not known	14. MOTHER'S MAIDEN NAME Not known	12. CITIZEN OF WHAT COUNTRY? US	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY No. Not known	17. INFORMANT Mrs. Myrtle Ward Accokeek Md.	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
422.2 Immediate cause (a) Cerebral Embolism			3 days
93d Antecedent cause(s) Chronic Myocarditis			4 yrs.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) None			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 1957, to Feb. 4, 1957, that I last saw the deceased alive on Feb 4, 1957, and that death occurred at 10 P m., from the causes and on the date stated above.

SIGNATURE	DATE SIGNED
Hunt & G. Susan L. Indian Head Md.	2-5-51
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 2-7-51
NAME OF CEMETERY OR CREMATORY Christ Church Cemetery	LOCATION (City, town, or county) Accokeek Md.
DATE REC'D BY LOCAL REG 2-7-51	REGISTRAR'S SIGNATURE Mrs. Alton Davis
24. FUNERAL DIRECTOR	ADDRESS
Hunt & Ryan	Waldorf Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS**

1748 242  
Reg. Dist. No. 234

1. PLACE OF DEATH COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>P.G.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Coral Hills</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Coral Hills</u>	
TOWN <u>Coral Hills</u>		TOWN <u>Coral Hills</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5305 Gue Street</u>		STREET ADDRESS (If rural, give location) <u>5305 Gue Street</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Frank D. Harold Canerly</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2 7 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>10-18-93</u>
9. AGE last birthday <u>57</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>New Hampshire</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Canerly</u>		14. MOTHER'S MAIDEN NAME <u>Mary Campbell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY No. <u>577-03-0601</u>	
17. INFORMANT AND ADDRESS <u>Bertha B. Canerly</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause <u>420.1 Coronary Occlusion</u>	(a)	
Antecedent cause(s) <u>131a Cardiovascular renal disease</u>	(b)	
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>James D. Boyd M.D.</u>		ADDRESS <u>Ineslarly Rd 2-7-57</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Feb 12 1957</u>	<u>Arlington National</u>	<u>Arlington Va</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Feb 8 1957</u>	<u>Howard F. Beest</u>	<u>Simmons Bros.</u>	<u>2007 Nichols</u>
<u>Camie F. Campbell</u>		<u>750836 ave S.E. Wash DC</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

1749

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>P-S</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bedbury Heights</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bedbury Heights</u>	
TOWN <u>Bedbury Heights</u>		TOWN <u>Bedbury Heights</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4802 Alton Street</u>		STREET ADDRESS (If rural, give location) <u>4802 Alton Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Elizabeth</u>	(Middle) <u>L.</u>	(Last) <u>Chapman</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12-12-1860</u>
9. AGE last birthday <u>90</u> yrs.		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>1</u> (Year) <u>1957</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Chapman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hanley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Family Bible</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
442x Immediate cause (a) <u>Congestive heart failure</u>			
131a Antecedent cause(s) (b) <u>Cardiovascular renal disease</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Old fractures of both hips</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.)	(CITY OR TOWN)	(COUNTY)
SUICIDE HOMICIDE	INJURY		
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>deputy medical examiner</u> , 19 <u>2/3</u> , to <u>2/3</u> , that I last saw the deceased alive on <u>2/3</u> , 19 <u>57</u> , and that death occurred at <u>4:00 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>James J. Boyd M.D.</u>		ADDRESS <u>Forestville Md</u>	
DATE SIGNED <u>2-1-57</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE <u>2/3/1957</u>	NAME OF CEMETERY OR CREMATORY <u>St Olivet Cemetery</u>	LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
DATE REC'D BY LOCAL REG. <u>Feb. 1-57</u>	REGISTRAR'S SIGNATURE <u>Carrie F. Campbell</u>	24. FUNERAL DIRECTOR <u>W. W. Chambers Co</u>	ADDRESS <u>517-11th St. S.E.</u>



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

1750

Reg. Dist. No. 231

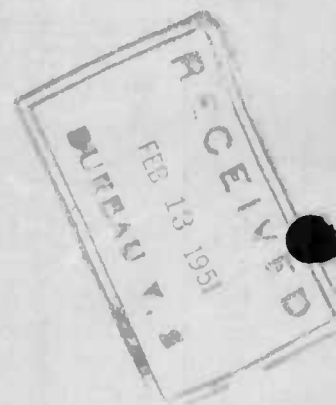
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Prince Georges	
CITY (If outside corporate limits, write RURAL and give nearest town) CHESAPEAKE		LENGTH OF STAY (In this place) 1 day		CITY (If outside corporate limits, write RURAL and give nearest town) College Park, Md.	
TOWN				TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince Georges Gen. Hosp.				STREET ADDRESS 4603 Dupont Road	
3. NAME OF DECEASED (Type or Print) Edna Irene Cusivell		(First) (Middle) (Last)		4. DATE OF DEATH Feb 8 1951	
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	
8. DATE OF BIRTH July 5, 1892		9. AGE last birthday 58 yrs.		10. BIRTHPLACE (State or foreign country) Indiana	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		12. KIND OF BUSINESS OR INDUSTRY Gen'l. Employ		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME Peter Wolf		15. MOTHER'S MAIDEN NAME Sylvia Waltrou		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY No.		18. INFORMANT AND ADDRESS Mrs. James W. Dawson			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Shock			
Antecedent cause(s) (b) Cardiovascular disease			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 2nd & 3rd degree burns of body			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death. Diabetes mellitus Hemiplegia (left)			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> PLACE (Home, farm, factory, street, office bldg., etc.) Home		(CITY OR TOWN) College Park - Pr. Geo. County, Md.	
TIME (Month) (Day) (Year) (Hour) OF INJURY 2-7-51 10:30 A.M.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? 1st residence fire ignition of bed clothing by cigarette lighter			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE John W. Maloney M.D. Dep. Md. Exam.		DATE SIGNED 2-8-51	
23. BURIAL, CREMATION REMOVAL (Specify) Entombment		DATE THEREOF Feb 10, 1951	
NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		LOCATION (City, town, or county) Colmar Manor Maryland	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 2/9/51 Amanda Drury		24. FUNERAL DIRECTOR F. Gasch's Sons	
		ADDRESS Hyattsville Maryland.	

UVV 916





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH - COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Ind</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write nearest town) <u>Lanham Ind</u>		CITY (If outside corporate limits, write nearest town) <u>Lanham Ind</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>JULIA</u> (Middle) <u>FARISH</u> (Last) <u>DOWNES</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>9</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>9/20/1854</u>
9. AGE last birthday <u>96</u> yrs.		10. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>William F. Farish</u>		14. MOTHER'S MAIDEN NAME <u>Marcella Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Richard F. Downes Lanham Ind</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

## Immediate cause

(a)

## Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-10, 1934, to 2-9, 1951, that I last saw the deceasedalive on 2-9, 1951, and that death occurred at 8 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE OF THE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1752 243

1. PLACE OF DEATH - COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>D. C.</u> COUNTY <u>-</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glenn Dale (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Sanatorium</u>		STREET ADDRESS (If rural, give location) <u>35 Eye St., N. E.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>BERTHA</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>DUBOIS</u> <u>2</u> <u>23</u> <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>12/25/12</u>
9. AGE last birthday <u>38</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>	
11. BIRTHPLACE (State or foreign country) <u>Brunswick, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Rosa ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Decedent</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) Pulmonary Tuberculosis, Far Advanced

INTERVAL BETWEEN ONSET AND DEATH  
9 mon.

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2/19, 1951, to 2/23, 1951, that I last saw the deceased

alive on 2/23, 1951, and that death occurred at 5:40 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>✓</u>	DATE THEREOF <u>2/24/51</u>	NAME OF CEMETERY OR CREMATORY <u>Glenn Dale Sanatorium</u>	LOCATION (City, town, or county) <u>Glenn Dale, Maryland</u>	(State) <u>MD</u>
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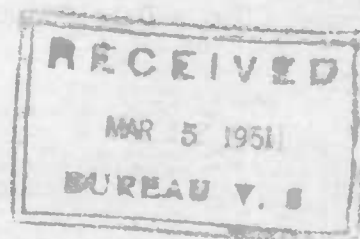
DATE REC'D BY LOCAL REG. <u>2/24/51</u>	REGISTRAR'S SIGNATURE <u>W. E. Weiss</u>	24. FUNERAL DIRECTOR <u>Frager</u>	ADDRESS <u>Funeral Home 784679</u>
--	---	---------------------------------------	---------------------------------------

389. (P). Am. N. H.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH- COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
TOWN <u>Laurel</u>		TOWN <u>Laurel</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1103 Montgomery St</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Burke</u> (Middle) <u>John</u> (Last) <u>Dwyer</u>		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>6</u> (Year) <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 31 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B &amp; O Railroad</u>	9. AGE last birthday <u>66 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John Paul Dwyer</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Turner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>705-09-1582</u>	
17. INFORMANT AND ADDRESS <u>Mrs Margaret Dwyer - Laurel Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Bronchogenic Carcinoma</u>		<u>1 1/2 yrs.</u>
Antecedent cause(s) (b) <u>Metastatic Ca to Spine</u>		<u>1 wk</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Chronic Bronchitis</u>		<u>10 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 9-20, 1957, to 2/6, 1951, that I last saw the deceased alive on 2/6, 1951, and that death occurred at 5:45 PM from the causes and on the date stated above.

SIGNATURE <u>J. M. Warner Md</u>	DATE SIGNED <u>2/8/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Feb. 9 1951</u>
NAME OF CEMETERY OR CREMATORY <u>Sanage Cemetery</u>	LOCATION (City, town, or county) <u>Sanage, Maryland</u>
24. FUNERAL DIRECTOR <u>W. H. Witt</u>	ADDRESS <u>Sanage, Maryland</u>

DATE SENT BY LOCAL REG. Feb 9-51

REGISTRAR'S SIGNATURE M. Brashear

690506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
FEB 14 1951  
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

Reg. Dist. No. *2/5*

1. PLACE OF DEATH: COUNTY <i>Prince Georges</i> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <i>Landover</i> TOWN <i>Landover</i> HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Selander Memorial Hosp.</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>D.C.</i> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i> TOWN <i>Gaithersburg</i> STREET ADDRESS (If rural, give location) <i>80 A. Island City Homes</i>	
3. NAME OF DECEASED (Type or Print) (First) <i>Eric</i> (Middle) <i>Marshall</i> (Last) <i>Fitzgibbons</i>		4. DATE OF DEATH (Month) <i>Feb</i> (Day) <i>20</i> (Year) <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Oct. 16, 1922</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>28</i> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTH PLACE (State or foreign country) <i>Arkansas</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Arthur Jacobs</i>		14. MOTHER'S MAIDEN NAME <i>Belle Christopher</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <i>Frank C. Fitzgibbons - Husband.</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <i>Hemorrhage &amp; shock.</i>		
Antecedent cause(s) (b) <i>Crushed chest</i>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Automobile Collision</i>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <i>Street</i>	(CITY OR TOWN) <i>College Park - Md.</i> (COUNTY) <i>Pr. Geo.</i> (STATE) <i>Md.</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>2-20-51 2:30 a.m.</i>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <i>Collision between automobile &amp; train. Driver.</i>

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE <i>John W. Malone, M.D., Dep. Med. Exam.</i>	ADDRESS <i>Cherry Hill, Hyattsville, Md.</i>	DATE SIGNED <i>2-20-51</i>
23. BURIAL, CREMATION, REMOVAL (Specify) <i>2/21/51</i>	NAME OF CEMETERY OR CREMATORY <i>Gaithersburg</i>	LOCATION (City, town, or county) (State) <i>D.C.</i>
DATE REC'D BY LOCAL REG. <i>Feb. 20, 1951</i>	REGISTRAR'S SIGNATURE <i>Mrs. Jas. Severe (Deputy)</i>	24. FUNERAL DIRECTOR <i>Lucas &amp; Sons Hyattsville Md.</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u> LENGTH OF STAY (In this place) <u>10 years</u> TOWN <u>Chesapeake</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George General Hosp</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Pr. George</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u> OR TOWN <u>4907-37th Street</u> STREET ADDRESS <u>Brentwood, Md</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Holloway</u> <u>Ennora</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2-14</u> <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5-17-1880</u>
9. AGE last birthday <u>70</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Journalist</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Journalist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Ennora Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>577-05-2870</u>	
17. INFORMANT AND ADDRESS <u>Ennora Holloway</u> <u>Wife</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
976x Immediate cause (a) <u>Hemorrhage &amp; shock</u>		
164c Antecedent cause(s) (b) <u>Gunsight Wound of head</u>		
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u> (CITY OR TOWN) <u>Brentwood</u> (COUNTY) <u>Pr. Geo</u> (STATE) <u>Md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2-14-51</u> <u>2:30</u> p.m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>Self-inflicted</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE <u>John W. Maloney M.D. Dip. Med. Examin. Chesh. Hyattsville Md</u>		DATE SIGNED <u>2-14-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/17/51</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Switzland, Md.</u>
DATE REC'D BY LOCAL REG. <u>Feb 16 1951</u>	REGISTRAR'S SIGNATURE (Deputy) <u>Amanda Downey</u>	24. FUNERAL DIRECTOR <u>Halliday's Funeral Home</u> ADDRESS <u>3200-9th St. Island Ave, Mt Rainier</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 51 1961  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 1756 242

## 1. PLACE OF DEATH:

County Prince George  
 City or town Suitland Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 31 yrs  
 Hospital, institution, or street address where death occurred

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince George  
 City or town Suitland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4719 Summer Rd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war none

## 3. (a) FULL NAME

Henry John Hagen

## 3. (b) Social Security Number

none4. Sex Male 5. Color or race W 6. (a) Single, married, widowed, or divorced marriedB. (b) Name of husband or wife Margaret Hagen

8. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Oct. 21-18628. AGE: Years 88 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Germany  
(Town, county, and state)10. Usual occupation Laborer11. Industry or business Fleishman's Yeast12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Karl H. HagenAddress 4719 Summer Rd. S.E17. Burial (burial, cremation, or removal) Which? Burial Date thereof 2/10/51  
(month) (day) (year)Cemetery or crematory Cedar HillLocation Suitland Md.18. Funeral director W. W. Chambers Co.Address 517 11th St S.E. DC19. Feb 7 19 51 Carrie S. Campbell  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 19 51 at 8:25 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2 19 51 to Feb 7 19 51and that I last saw him alive on Feb 6 19 51

Immediate cause of death

Bronchopneumonia 6 daysand Coronary Occlusion 6 daysGeneral arteriosclerosis unknown

Due to \_\_\_\_\_

Other conditions 426.1

94a (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide natural cause Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Paul E. SmithAddress Washington DC Date signed Feb 7 19 51



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>D. C.</u> COUNTY <u>-</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glenn Dale (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Sanatorium</u>		STREET ADDRESS (If rural, give location) <u>421 L. St., N. W.</u>	
3. NAME OF DECEASED (Type or Print) <u>JAMES</u> (First) <u>O</u> (Middle) <u>HOWELL</u> (Last)		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1/29/1908</u>
9. AGE last birthday <u>43</u> yrs.		10. If under 1 year Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>F. W. A. cleaner</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Issac J. Howell</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Hill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>240-03-0505</u>	
17. INFORMANT AND ADDRESS <u>Decedent</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Tuberculosis

Antecedent cause(s) (b) 002X

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 13b

INTERVAL BETWEEN ONSET AND DEATH  
4 years 6 mos

#### II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

#### 20. AUTOPSY?

Yes ☒ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at ☐ Not While ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/2, 1946, to 2/16, 1951, that I last saw the deceased

alive on 2/16, 1951, and that death occurred at 12:36 a.m., from the causes and on the date stated above.

SIGNATURE Daniel Leo Pincus

M. D.

ADDRESS Glenn Dale Sanatorium

DATE SIGNED 2/16/51

23. BURIAL, CREMATION REMOVAL (Specify) 2-17-51

DATE THEREOF

NAME OF CEMETERY OR CREMATORY Glenn Dale, Maryland

LOCATION (City, town, or county) Washington D.C.

(State)

DATE REC'D BY LOCAL REG. 2/16/51

REGISTRAR'S SIGNATURE W. Weiss

24. FUNERAL DIRECTOR Mahon & Schuy Inc.

ADDRESS 424-R St. N.W.

690916

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 26 1951  
BUREAU V. S.



2022

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

1758

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington, D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4310-44th Street</u>		STREET ADDRESS <u>3226 Wallbridge P. N.W.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Nathan</u>	(Middle) _____	(Last) <u>Hymen</u>
4. DATE OF DEATH	(Month) <u>Feb.</u>	(Day) <u>12</u>	(Year) <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>4-23-01</u>
9. AGE last birthday <u>49</u> yrs.	If under 1 year Months _____ Days _____	If under 24 hrs Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>	11. BIRTH PLACE (State or foreign country) <u>Russia</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>Max Hymen</u>	14. MOTHER'S MAIDEN NAME <u>Francis Shone</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY No. _____	17. INFORMANT AND ADDRESS <u>Joseph Hymen Brother</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Occlusion</u>			
Antecedent cause(s) (b) <u>Cardiovascular renal disease</u>			
Disease or condition(s), if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerosis</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes Mellitus</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>John J. Maloney M.D. Dep. M.D. Exam. Churchoy</u>		DATE SIGNED <u>2-12-51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>12 Feb 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Goldberg Funeral Home</u>	LOCATION (City, town, or county) (State) <u>Hyattsville, D.C.</u>
DATE REC'D BY LOCAL REG. <u>2/12/51</u>	REGISTRAR'S SIGNATURE <u>Amanda Dourney</u>	24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>	ADDRESS <u>Hyattsville, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

390636

RECEIVED  
FEB 17 1961  
N. A. D. M. A. M. A. M.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1759 242

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Pr. Geo</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lanham Park</u>		STREET ADDRESS (If rural, give location) <u>Lanham Park</u>	
3. NAME OF DECEASED (Type or Print) <u>Paul</u> (First) <u>Le Roy</u> (Middle) <u>Jackson</u> (Last)		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>2/21/51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unemployed</u>	9. AGE last birthday <u>6</u> yrs. If under 1 year Months <u>6</u> Days <u>6</u> If under 24 hrs. Hours <u>6</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Lanham Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frank Lloyd Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Eda Sarah Pierce</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Frank Jackson - Father</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) congenital debility (#108)

## INTERVAL BETWEEN ONSET AND DEATH

Birth

## Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2/21, 1951, to 2/27, 1951, that I last saw the deceased alive on 2/26, 1951, and that death occurred at 6:10 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/27/51</u>	NAME OF CEMETERY OR CREMATORY <u>Glendale</u>	LOCATION (City, town, or county) <u>Glendale</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>2/27/51</u>	REGISTRAR'S SIGNATURE <u>Margaret L. Stanley</u>	24. FUNERAL DIRECTOR	ADDRESS	

102211 376 407

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A151

COPY SENT TO

C. H. Q.

DATE Mar 5, 1961

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY P. 5	
CITY (If outside corporate limits, write RURAL and give nearest town) Silver Hill		CITY (If outside corporate limits, write RURAL and give nearest town) Silver Hill	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3650 Branch Ave		STREET ADDRESS (If rural, give location) 3650 Branch Ave	
3. NAME OF DECEASED (First) Marshall (Middle) Edward (Last) Jones		4. DATE OF DEATH (Month) 2 (Day) 17 (Year) 1977	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Specified	8. DATE OF BIRTH about 1889
9. AGE last birthday 61 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevedore		10b. KIND OF BUSINESS OR INDUSTRY Various	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME William H. Jones		14. MOTHER'S MAIDEN NAME Marian Dawson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Lawrence E. Jones			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Coronary Occlusion		
420.1 Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last 131a Cardiovascular renal disease		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
		HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
Lawrence E. Jones		M.D.		Fagerstone Md		2-17-51	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF Feb 17 1951		NAME OF CEMETERY OR CREMATORY Rainville Va		LOCATION (City, town, or county) Rainville Va (State)	
DATE REC'D BY LOCAL REG. Feb 17 1951		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
		R. Smith		A. H. Jones Jr.		Rainville Va	

4904 W. JONES FUNERAL HOME

RECEIVED  
FEB 20 1951  
BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH- COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Prince Georges County	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Greenbelt Md		CITY (If outside corporate limits, write RURAL and give nearest town) OR Greenbelt Md	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) 1 G Northway	
3. NAME OF DECEASED (Type or Print) (First) Michael (Middle) (Last) Juliano		4. DATE OF DEATH Feb 18, 1951- 19	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 4/5/1885
9. AGE last birthday 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber Valentine Barber Shop	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Gayton Juliano		14. MOTHER'S MAIDEN NAME Filomena ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 577/18- 5574	
17. INFORMANT AND ADDRESS Pauline Julianno Greenbelt Md.			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

153x Immediate cause

(a) Carcinoma of Colon, with metastases

2 yrs.

Antecedent cause(s)

462 Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c) Carcinoma of Colon; pulmonary and hepatic metastases

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Colon		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb 6, 1951, to Feb 18, 1951, that I last saw the deceased

alive on Feb 18, 1951, and that death occurred at 9:15 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 2/21/51		NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		LOCATION (City, town, or county) Washington D. C.		(State)	
---	--	-------------------------	--	---	--	--	--	---------	--

DATE REC'D BY LOCAL REG

2/21/51

REGISTRAR'S SIGNATURE

John W. Smith

24. FUNERAL DIRECTOR

F. Gasch's sons Hyattsville Maryland.

ADDRESS

740849

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



0459



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH - COUNTY <u>Brown George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>B. Geo</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>East Rwerdale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Brown George's Gen. Hospital</u>		STREET ADDRESS (If rural, give location) <u>5412 56th Place</u>	
3. NAME OF DECEASED (Type or Print) <u>Baby Newman</u>	(First) (Middle) (Last)	4. DATE OF DEATH <u>Feb. 23</u>	(Month) (Day) (Year)
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>July 23, 1950</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>7</u> yrs. <u>1</u> month <u>1</u> day <u>1</u> hour <u>1</u> min.
11. FATHER'S NAME <u>Mr. Newman Kimbrough Jr.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. MOTHER'S MAIDEN NAME <u>Betty Kimbrough</u>		14. BIRTHPLACE (State or foreign country) <u>Maryland Wash. DC</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

## Immediate cause

(a) Bronchopneumonia

## Antecedent cause(s)

(b) Cleft Palate

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb. 20, 1951, to Feb. 23, 1951, that I last saw the deceased alive on Feb. 23, 1951, and that death occurred at 8:45 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>2/23/1951</u>	<u>Expos. &amp; Montgomerie Ala.</u>		
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2/23/51</u>	<u>Amanda Dauney</u>	<u>J. William Feis Sons Co.</u>	<u>300-4 St. N.E. Wash. DC</u>	

207220231405

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

RECEIVED

RECEIVED  
FEB 26 1951  
BUREAU V. V.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1763 248

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>New York</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Thurston</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Jamaica, Long Island</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Selander Memorial Hosp.</u>		STREET ADDRESS (If rural, give location) <u>143-14 - 91st Ave</u>	
3. NAME OF DECEASED (First) <u>Matthe</u> (Middle) <u>Spurny</u> (Last) <u>Idem</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-16-1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>57</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Max Spurny</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Spurny</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital records</u>		17. ADDRESS	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

8165 Immediate cause (a) Hemorrhage & shock  
1700 Antecedent cause(s) (b) Crushed chest  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE <u>Accident</u> HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Street</u>	(CITY OR TOWN) <u>Riverdale - Pr. Geo.</u> (COUNTY) <u>Nich.</u> (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2-1-51</u> <u>1:00</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Passenger in auto, which collided with another automobile</u>

22. I hereby certify that I attended the deceased from ..... 19....., to ..... 19....., that I last saw the deceased alive on ..... 19....., and that death occurred at 7:30 p m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>2-2-51</u>	NAME OF CEMETERY OR CREMATORY <u>West Pleasant Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hyaltonville, Md.</u>
DATE RECD BY LOCAL REG. <u>Feb 2, 1951</u>	REGISTRAR'S SIGNATURE <u>James Levey</u>	24. FUNERAL DIRECTOR <u>Gaschione Hyaltonville Md</u>	ADDRESS

Buried Date: 2/4/51

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH - COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED - STATE D. C. COUNTY -			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glenn Dale, (Rural)				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Sanatorium				STREET ADDRESS (If rural, give location) 125 E. St., N. W.			
3. NAME OF DECEASED (Type or Print) DANIEL		(First) A.		(Last) KOONTZ		4. DATE OF DEATH (Month) 2 (Day) 3 (Year) 19 51	
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Separated		8. DATE OF BIRTH 1/27/1899	
9. AGE last birthday 52 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY J. H. Bowman		11. BIRTHPLACE (State or foreign country) Rockingham, Va.	
13. FATHER'S NAME Reuben Koontz				14. MOTHER'S MAIDEN NAME Amanda Good			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY No. 579-05-1056		17. INFORMANT AND ADDRESS Decedent	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 4 yrs.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) pulmonary tuberculosis							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) SUICIDE HOMICIDE				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			
HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from 9-29, 1950, to 2-3, 1951, that I last saw the deceased alive on 2-3, 1951, and that death occurred at 7:45 a.m., from the causes and on the date stated above.							
SIGNATURE Daniel Leo Pinnane M.D.				DATE SIGNED 2/3/51			
23. BURIAL, CREMATION REMOVAL (Specify) 2/3/51				NAME OF CEMETERY OR CREMATORY Glenn Dale Sanatorium, Glenn Dale, Maryland			
DATE REC'D BY LOCAL REG. 2/4/51				24. FUNERAL DIRECTOR F. Gaschi Sone Hyattsville Md			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

753246





MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

1765

Reg. Dist. No. 239

1. PLACE OF DEATH. COUNTY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Laurel</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Warren's Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Laurel</u> STREET ADDRESS (If rural, give location) <u>Baltimore Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Gillis A. Lewis</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 14 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>DIVORCED</u>	8. DATE OF BIRTH <u>7-6-1906</u>
9. AGE last birthday <u>44</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen Motors</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Luther L Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Emma B. Henderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>578-10-9431</u>	
17. INFORMANT AND ADDRESS <u>Richard H. Lewis 431 6th st., Wash., D.C.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral compression</u>		
Antecedent cause(s) (b) <u>Intra cranial hemorrhage</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertension</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>		<u>2/16/51</u>	<u>Belmont Cemetery</u>	<u>Belmont</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR			
<u>Feb 19-51</u>	<u>M. Brashear</u>	<u>W.W. Chambers Co. Wash. D.C.</u>			

550816

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 20 1991  
BUREAU V.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

1766

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE D.C. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale (Rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Sanatorium		STREET ADDRESS (If rural, give location) 476- E. St., S.W.	
3. NAME OF DECEASED (Type or Print) AILEEN A LINDSEY		4. DATE OF DEATH (Month) 2 (Day) 7 (Year) 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 5/9/16
9. AGE last birthday 34 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY -
11. BIRTHPLACE (State or foreign country) Martinburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Thompson		14. MOTHER'S MAIDEN NAME Ella Richardson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 121-09-3402	
17. INFORMANT AND ADDRESS Decedent			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)---

Pulmonary Tuberculosis

Antecedent cause(s)

(b)---

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)---

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Work Not While at work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/1, 1950, to 2/7, 1951, that I last saw the deceased

alive on 2/7, 1951, and that death occurred at 11:52a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Daniel Leo Pinckard

M.D.,

Glenn Dale Sanatorium

Glenn Dale, Maryland

2/7/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2/7/51

Helen Weiss

Daniel Leo Pinckard M.D. Glenn Dale Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED  
FEB 16 1951  
F. B. I.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Pr. George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George Gen. Hosp.</u>		STREET ADDRESS (If rural, give location) <u>4213 Ogletree Street</u>	
3. NAME OF DECEASED (Type or Print) <u>J. Leone</u>	(First) (Middle) (Last)	4. DATE OF DEATH <u>February 9, 1951</u>	(Month) (Day) (Year)
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>July 4, 1873</u>
			9. AGE last birthday <u>77</u> yrs. If under 1 year: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. FATHER'S NAME <u>Basel Smith</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. INFORMANT AND ADDRESS <u>Wilson Little Hallgren ra</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>W</u>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) Coronary Thrombosis

##### Antecedent cause(s)

(b) Hypertension

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Intercurrent

INTERVAL BETWEEN ONSET AND DEATH

6 days

#### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☐

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-3-, 1951, to 2-9-, 1951, that I last saw the deceased

alive on 2-9-51, 1951, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

#### 23. BURIAL CREMATION REMOVAL (Specify)

#### DATE THEREOF

#### NAME OF CEMETERY OR CREMATORY

#### LOCATION (City, town, or county)

#### (State)

DATE REC'D BY LOCAL REG. 2/10/51

REGISTRAR'S SIGNATURE

#### 24. FUNERAL DIRECTOR

#### ADDRESS

F. Gasch's Sons Hyattsville Maryland.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

RECEIVED

RECEIVED  
FEB 18 1951  
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

Reg. Dist. No. 245

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Riversdale</u> TOWN <u>Riversdale</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Selam Memorial Hosp</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Pr. Georges</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rogers Heights</u> TOWN <u>Rogers Heights</u> STREET ADDRESS (If rural, give location) <u>5505 Gallatin St.</u>	
3. NAME OF DECEASED (Type or Print) <u>George</u> (First) <u>Woodman</u> (Middle) <u>Locke</u> (Last)	4. DATE OF DEATH <u>2</u> - <u>25</u> 19 <u>51</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>7-19-1866</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Artist</u>	9. AGE last birthday <u>84</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Locke</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mr. Harley - Son-in-law</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
42010 Immediate cause (a) <u>Pulmonary edema</u>			<u>2 hrs</u>
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Coronary occlusion</u>			<u>2 hrs</u>
(c) <u>Arteriosclerotic heart disease</u>			<u>?</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

1769

Reg. Dist. No. *288*

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <i>Prince Georges</i> MARYLAND CITY (If outside corporate limits, write nearest town) <i>Hyattsville</i> LENGTH OF STAY (in this place) <i>9 years</i> TOWN <i>Hyattsville</i> HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>4114 Emerson St.</i>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Prince Georges Co.</i> CITY (If outside corporate limits, write nearest town) <i>Hyattsville</i> OR TOWN <i>Hyattsville</i> STREET ADDRESS (If rural, give location) <i>4114 Emerson St.</i>			
3. NAME OF DECEASED (Type or Print) <i>Irvin Van Lydick</i>		4. DATE OF DEATH (Month) <i>Feb.</i> (Day) <i>11</i> (Year) <i>1951</i>					
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Married</i>	8. DATE OF BIRTH <i>June 6, 1871</i>	9. AGE last birthday <i>79</i> yrs.	10. If under 1 year Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Refrigerator and Electrician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Refrigerator and Electrician</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>			
13. FATHER'S NAME <i>Stutchfield Lydick</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY No. <i>none</i>		17. INFORMANT AND ADDRESS <i>Margaret Lydick Daughter in law</i>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH		
<p>Immediate cause (a) <i>Acute congestive heart failure</i></p> <p>Antecedent cause(s) (b) <i>Aortic stenosis</i></p> <p>(c) <i>Rheumatic heart disease</i></p>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, or office bldg., etc.) OF INJURY		(CITY OR TOWN)	(COUNTY) (STATE)		
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE <i>John J. Mahoney, M.D., Dep. Med. Exam.</i>		ADDRESS <i>Chesley - Hyattsville Md.</i>		DATE SIGNED <i>2-11-51</i>			
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Transportation</i>		DATE THEREOF <i>2/12/51</i>		NAME OF CEMETERY OR CREMATORY <i>Indiana</i>			
DATE REC'D BY LOCAL REG. <i>Feb 12 1951</i>		REGISTRAR'S SIGNATURE <i>James Severy</i>		24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>			
				ADDRESS <i>Hyattsville Maryland.</i>			

690246



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 3461-14th St N.W. Washington D.C. ✓	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Home		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) Martina	(First)	(Middle) M.	(Last) Maher
4. DATE OF DEATH Feb. 20	(Month)	(Day)	(Year) 1957
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb 18/1868
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Productive work		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 83 yrs.
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Yes.	
13. FATHER'S NAME Michael Hart		14. MOTHER'S MAIDEN NAME Francisca Bauer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
17. INFORMANT Sacred Heart Home			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a)

##### Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb 19, 1957, to Feb 20, 1957, that I last saw the deceased

alive on Feb 20, 1957, and that death occurred at 1:15 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) Address DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
DATE REC'D BY LOCAL REG. 20 1957	REGISTRAR'S SIGNATURE James Severs	24. FUNERAL DIRECTOR	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 23 1951  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH: COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Prince Georges	
CITY (If outside corporate limits, write RURAL and give nearest town) Columbia Park		CITY (If outside corporate limits, write RURAL and give nearest town) Columbia Park	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Columbia & Linwood Ave.		STREET ADDRESS (If rural, give location) Columbia & Linwood Ave.	
3. NAME OF DECEASED (Type or Print) Charles (First) Bertram (Middle) Markes (Last)		4. DATE OF DEATH (Month) (Day) (Year) Feb 1 1957	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH July 1, 1872
9. AGE last birthday 78 yrs.		10. If under 1 year: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Charles R. Markes		14. MOTHER'S MAIDEN NAME Elizabeth Steele	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS John J. Markes, Brother			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause Acute congestive heart failure		
(b) Antecedent cause(s) Cardiovascular renal disease		
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

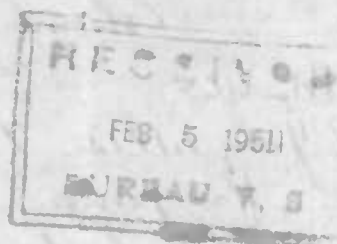
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 6-22-57, 19....., and that death occurred at 6:22 p.m., from the causes and on the date stated above.

SIGNATURE John J. Markes M.D. Dep. Med. Exam. - Church - Hyattsville Md. - 2-1-57		ADDRESS 641-24 St. N.E. Washington, D.C.		DATE SIGNED 2-1-57
23. BURIAL CREMATION REMOVAL (Specify) Burial	DATE THEREOF 2/5/57	NAME OF CEMETERY OR CREMATORY Cedar Hill	LOCATION (City, town, or county) Suitland, Md.	(State)
DATE REC'D BY LOCAL REG. 2/2/57	REGISTRAR'S SIGNATURE Amanda Doney	24. FUNERAL DIRECTOR Timothy Danlov	ADDRESS 641-24 St. N.E. Washington, D.C.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





Evidence for change  
in 9 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1772 245

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>College Park Md</u>	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4322 Rowlett Drive Apt # 201</u>		STREET ADDRESS (If rural, give location) <u>4322 Rowlett Drive</u>	
3. NAME OF DECEASED (Type or Print) <u>ECHO</u> (First) <u>NEVADA</u> (Middle) <u>MULNIX</u> (Last)		4. DATE OF DEATH (Month) <u>FEB</u> (Day) <u>23</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 16, 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZENSHIP OF DECEASED <u>U.S.C.</u>	
13. FATHER'S NAME <u>Walter Fuller</u>		14. MOTHER'S MAIDEN NAME <u>Fuller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT <u>McIntyre Fuller College Park Md</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute Pulmonary Congestion</u>			<u>6 hrs</u>
Antecedent cause(s) (b) <u>Chronic Myocarditis</u>			<u>?</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Bronchial Asthma</u>			<u>?</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office hldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/22, 1951, to 2/23, 1951, that I last saw the deceased alive on 2/22, 1951, and that death occurred at 7:40 A m., from the causes and on the date stated above.

SIGNATURE Dr. Etienne M.D. ADDRESS College Park, Md DATE SIGNED 2/23/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE <u>2/26/51</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	LOCATION (City, town, or county) <u>Swirland Md</u> (State)
DATE REC'D BY LOCAL REG. <u>Feb 24 1951</u>	REGISTRAR'S SIGNATURE <u>JAMES SURVEY</u>	24. FUNERAL DIRECTOR <u>E. Pasche Sons</u>	ADDRESS <u>Hyattsville Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>D.C.</u> COUNTY <u>-</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glenn Dale (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Sanatorium</u>		STREET ADDRESS (If rural, give location) <u>Blue Plain's Home</u> ✓	
3. NAME OF DECEASED (First) <u>GEORGE</u> (Middle) <u>NORTH</u> (Last) <u>NORTH</u>		4. DATE OF DEATH (Month) <u>FEB.</u> (Day) <u>5</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>3/15/1888</u>
9. AGE last birthday <u>62</u> yrs.		10. If under 1 year: Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elevator Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Hazleton, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Chas. North</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>National Guard, Pa.</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Decedent</u>			

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

2 yr. 10 mo.

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

### 20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from MAY 19, 1948, to FEB. 5, 1951, that I last saw the deceased alive on FEB. 5, 1951, and that death occurred at 6:20 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

Glenn Dale Sanatorium

DATE SIGNED

Daniel Leo Finucane M.D.

Glenn Dale, Maryland

2/5/51

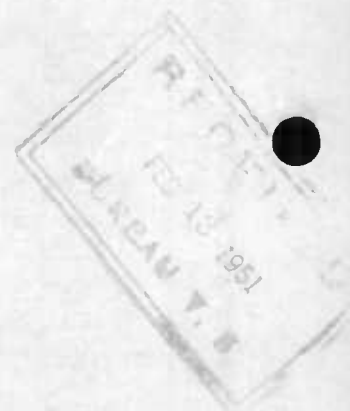
23. BURIAL OR CREMATION REMOVAL (Specify)	DATE THEREOF <u>2/7/51</u>	NAME OF CEMETERY OR CREMATORY <u>Washington National</u>	LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
DATE REC'D BY LOCAL REG. <u>2/6/51</u>	REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>	24. FUNERAL DIRECTOR <u>W. W. Chambers Co., Suitland, Md.</u>	ADDRESS

761VVV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *245*

1774

1. PLACE OF DEATH COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Pr. Geo.</i>	
CITY (If outside corporate limits, write or give nearest town) <i>College City</i>		CITY (If outside corporate limits, write or give nearest town) <i>College City</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>3805 - College Terrace</i>		STREET ADDRESS (If rural, give location) <i>3805 - College Terrace</i>	
3. NAME OF DECEASED (Type or Print) (First) <i>Beulah</i> (Middle) <i>Florence</i> (Last) <i>Padgett</i>		4. DATE OF DEATH (Month) <i>Feb</i> (Day) <i>16</i> (Year) <i>1951</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>3/28/1901</i>
9. AGE last birthday <i>49</i> yrs.		10. If under 1 year: Months <i>16</i> Days <i>16</i> Hours <i>19</i> Mins. <i>51</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Insurance operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John A. Rhine</i>		14. MOTHER'S MAIDEN NAME <i>Beulah F. Rhine</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>578-20-2463</i>	
17. INFORMANT AND ADDRESS <i>John H. Padgett 3805 - College Terrace</i>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) *Generalized Metastases - carcinoma*

##### Antecedent cause(s)

(b) *Cancer of Breast with metastases*

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c) *Cancer of Breast*

#### INTERVAL BETWEEN ONSET AND DEATH

*2 weeks*

*1 yr.*

*3 yrs*

#### 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

##### 19a. DATE OF OPERATION

##### 19b. MAJOR FINDINGS OF OPERATION

*March 1947*

*Cancer of Breast*

#### 20. AUTOPSY?

Yes ☐ No ☒

##### 21. ACCIDENT SUICIDE HOMICIDE (Specify)

##### PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *March 1947*, to *Feb. 16, 1951*, that I last saw the deceased

alive on *Feb. 16, 1951*, and that death occurred at *12:59 a.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*James H. Scully M.D.*

*M.D.*

*1835 Eye St NW, Washington D.C.*

*2-16-51*

##### 23. BURIAL, CREMATION REMOVAL (Specify)

##### DATE THEREOF

##### NAME OF CEMETERY OR CREMATORY

##### LOCATION (City, town, or county)

##### (State)

##### DATE REC'D BY LOCAL REG.

##### REGISTRAR'S SIGNATURE

##### 24. FUNERAL DIRECTOR

##### ADDRESS

*Feb 16 1951*

*Mrs. Jas. Severo (Deputy)*

*Malley's Funeral Home 3200 - R.I. Ave.*

*mt. Rainier, Md. 761916*

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

1775

Reg. Dist. No. 242

1. PLACE OF DEATH COUNTY <u>Prince George County</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rosaryville</u> TOWN <u>MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Pri. Geo.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rosaryville</u> TOWN <u>Rosaryville</u> STREET ADDRESS <u>Crown Highway</u>	
3. NAME OF DECEASED (Type or Print) <u>Claudia</u> (Middle) <u>Parker</u> (Last)		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>10-28-1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Reg. Nurse</u>	9. AGE last birthday <u>56</u> yrs.
13. FATHER'S NAME <u>William Henry Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Alice Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>10-28-1894</u>	
17. INFORMANT <u>Bertrude Stevenson</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. America</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Acute Dilatation of Heart</u>				<u>1 day</u>	
Antecedent cause(s) (b) <u>Hypertension</u>				<u>5 yrs</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Nephritis</u>				<u>3 yrs</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis</u>				<u>10 yrs</u>	
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>no</u>	(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Feb. 28, 1951, to Feb. 24, 1951, that I last saw the deceased alive on Feb. 24, 1951, and that death occurred at 11:45 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) James E. Parker M.D. - Upper Marlboro - Md ADDRESS 4339 Hunt Pl. DATE SIGNED Feb. 27-51

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>2-28-51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Simon Cem.</u>	LOCATION (City, town, or county) <u>Croome Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>Feb. 27-51</u>	REGISTRAR'S SIGNATURE <u>Carrie F. Campbell</u>	24. FUNERAL DIRECTOR <u>Myrtle K. Bolkins</u> ADDRESS <u>4339 Hunt Pl.</u>		

781 868 N.E. Wash, D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 231  
2018

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) Cheverly TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince Georges General		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Prince Georges CITY (If outside corporate limits, write RURAL and give nearest town) Cheverly TOWN STREET ADDRESS (If rural, give location) 3202-Cheverly-Cove	
3. NAME OF DECEASED (Type or Print) William Parker	4. DATE OF DEATH (Month) 2 (Day) 2 (Year) 1957	5. SEX Male	6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 6-20-39	9. AGE last birthday 18 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student
11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME William Parker	14. MOTHER'S MAIDEN NAME Agnes Heyning
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS William Parker - Father	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Shock	Antecedent cause(s) (b) Retro, ventral hemorrhage	
936.5 195e	(c) Rupture of spleen	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY Street	(CITY OR TOWN) Cheverly (COUNTY) Pr. Geo. (STATE) Md.
TIME (Month) (Day) (Year) (Hour) OF INJURY 2-1-51-11:45 m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR Ran into a pole while shodding into door

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE John W. Loney, M.D., Dep. Med. Exam. - Cheverly Hyattsville Md. 3-51		DATE SIGNED	
23. MANNER OF DEATH Removal of remains	DATE THEREOF 3-25-1951	NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	LOCATION (City, town, or county) Hyattsville, Md.
DATE REC'D BY LOCAL REG. 4-1-1951	REGISTRAR'S SIGNATURE Amanda Loney	24. FUNERAL DIRECTOR 3. Sanchez Sons	ADDRESS Hyattsville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:  
County PRINCE GEORGE  
City or town CHILLUM, MD  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 MONTHS  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County PRINCE GEORGE  
City or town  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1209 Chillum Manor Rd  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

ANTONIO PIRRONE

### 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced MARRIED  
6. (b) Name of husband or wife FRANCESCA  
7. Birth date of deceased (mo., day, yr.) SEPT 14, 1877  
6. (c) If alive, give age years  
8. AGE: Years 73 Months Days If less than one day  
hrs. min.

9. Birthplace Italy  
(Town, county, and state)  
10. Usual occupation Retired policeman  
11. Industry or business  
12. Name AUSTIN PIRRONE  
13. Birthplace ITALY  
14. Maiden name ROSARIO RUSSO  
15. Birthplace ITALY

16. Informant MRS. AUSTIN A PIRRONE  
Address 1209-CHILLUM MANOR ROAD  
17. BURIAL Date thereof 7 TO 1951  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory St. Mary's  
Location WASH. D.C.

18. Funeral director Bluffell  
Address 475-H St. N. H. Ab

19. Feb 18 1951 (Date rec'd by registrar) Mrs. Joe Serrano Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1951 at 3:00 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1951 to Feb 17 1951  
and that I last saw him alive on Feb 15 1951  
Immediate cause of death Myocardial Infarction  
Due to Coronary Failure  
Other conditions Diabetes  
422.2 (Include pregnancy within 3 months of death)  
Major findings of operations None  
Date of op.  
Autopsy results None  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

### DURATION

5 years  
2 days  
6 months

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE Ramon P. Aidman M.D.  
M. D. or other  
Address 1336 Missouri Ave Date signed 2-17-51

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 20 1951  
BUREAU V. I.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1778 243

1. PLACE OF DEATH: COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D. C. COUNTY -	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale, (Rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington,	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Sanatorium		STREET ADDRESS (If rural, give location) 4300 Alabama Ave., S. E. ✓	
3. NAME OF DECEASED (Type or Print) FLORENCE R. POWELL		4. DATE OF DEATH (Month) (Day) (Year) 2 15 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 7/4/1890
9. AGE last birthday 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary	
11. BIRTHPLACE (State or foreign country) Albam. Albemarle Co, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Johnson Richard		14. MOTHER'S MAIDEN NAME -	
15. WAS DECEASED EVER IN U.S./ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No -		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Decedent			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Pulmonary tuberculosis, Far Advanced

INTERVAL BETWEEN ONSET AND DEATH

26 years

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 11/29, 1946, to 2/15, 1951, that I last saw the deceased alive on 2/15, 1951, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

Glenn Dale Sanatorium

DATE SIGNED

Glenn Dale, Md.

2/15/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION, (City, town, or county)	(State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
2/15/51	Woe Weiss	J. William Lee's Sons Co.	350 536	
		300 - 4th St. N.E. Wash. D.C.		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
FEB 20 1961  
BUREAU V



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition  
in #23 shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1779

FILE No. G 131 MAR 2 1951

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Prince Georges</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Andrews AFB,</b>		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <b>Washington 25, D. C.</b>		TOWN <b>Upper Marlboro</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <b>RFD #1</b>	
3. NAME OF DECEASED (First) <b>Augustine</b> (Middle) <b>Everett</b> (Last) <b>Proctor</b>		4. DATE OF DEATH (Month) <b>Feb</b> (Day) <b>19</b> (Year) <b>1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>1 April 1909</b>
9. AGE last birthday <b>41</b> yrs.		10. If under 1 year Months <b>19</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Base</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>May 43-Jan 46</b>		16. SOCIAL SECURITY No. <b>577-09-1675</b>	
17. INFORMANT AND ADDRESS <b>Civilian Personnel Records</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <b>Acute Myocardial Infarction</b>			
Antecedent cause(s) (b) <b>None</b>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>			
19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION <b>None</b>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <b>SUICIDE</b>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN) <b>Andrews AFB,</b>	(COUNTY) <b>Prince Georges</b> (STATE) <b>Md.</b>
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>m.</b>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... 2:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) **James C. Andrews, Lt. USAF (MC)** ADDRESS **1050th Medical Gp** DATE SIGNED **19 Feb 51**

23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>2/23/51</b>	NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l</b>	LOCATION (City, town, or county) <b>Arlington, Va.</b>	(State)
DATE REC'D BY LOCAL REG. <b>19 Feb 51</b>	REGISTRAR'S SIGNATURE <b>Alma R. Hall</b>	24. FUNERAL DIRECTOR <b>The McQuire Funeral Serv.</b>	ADDRESS <b>1820 4th - Street, N.W. - H.B. 970916</b>	

MARGIN RESERVED FOR BINDING

VS. A15-1

RECEIVED  
FEB 27 1951  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

1780

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH CITY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Prince Georges, Md</u> LENGTH OF STAY <u>20.0.7</u> TOWN <u>Prince Georges</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Selma Memorial Hosp.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Texas</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) <u>Gabeston</u> TOWN <u>Gabeston</u> STREET ADDRESS <u>5002 - Avenue S.</u> (If rural, give location) <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or Print) <u>Allen</u>		(First) <u>Allen</u>		(Middle) <u>Rychart</u>		(Last) _____	
4. DATE OF DEATH <u>Feb-20</u>		(Month) <u>Feb</u>		(Day) <u>20</u>		(Year) <u>1957</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Aug. 8, 1926</u>	
9. AGE last birthday <u>24</u> yrs.		If under 1 year Months _____ Days _____		If under 24 hrs. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Texas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Al. Lawrence Martini</u>				14. MOTHER'S MAIDEN NAME <u>Kathryn Gentsch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____				16. SOCIAL SECURITY No. _____		17. INFORMANT AND ADDRESS <u>Miriam Boden - Sister</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
816.5 Immediate cause (a) <u>Hemorrhage &amp; shock</u>							
170c Antecedent cause(s) (b) <u>Fractured skull &amp; pelvis</u>							
(c) <u>Automobile collision</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION _____			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> PLACE (Home, farm, factory, street, office, etc.) <u>Street</u>				(CITY OR TOWN) <u>College Park - Pr. Geo. - Md.</u> (COUNTY) _____ (STATE) _____			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2-20-57 2:30 A.M.</u>				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>Collision between automobile &amp; trailer truck - Passenger</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>							
SIGNATURE <u>John J. Maloney, M.D., Dep. Med. Ex.</u>				DATE SIGNED <u>Feb 20 1957</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				DATE THEREOF <u>2/21/57</u>			
NAME OF CEMETERY OR CREMATORY <u>Salveston</u>				LOCATION (City, town, or county) <u>Texas</u> (State) _____			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Feb 20 1957 Mrs. Gao. Severe (Deputy)</u>				24. FUNERAL DIRECTOR <u>L. Pasche</u> ADDRESS <u>Hyattsville Md</u>			

VS-A15A

RECEIVED  
FEB 23 1951  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Life of correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change  
in #8 shown on:

FILE No. G 131 MAR 5 1951

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

### 1. PLACE OF DEATH:

County Brown  
City or town Accutson Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? yes  
Hospital, institution, or street address where death occurred:  
710  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County PG  
City or town Accutson Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 710 Accutson Rd SE Wash DC  
(If rural, give LOCATION)  
2(a) If veteran, name war 20

### 3. (a) FULL NAME

James E. Sanders

### 3. (b) Social Security Number

700

4. Sex M 5. Color or race M 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Sarah Elizabeth  
7. Birth date of deceased (mo., day, yr.) Aug 5 - 1880  
8. AGE: Years 71 Months 70 Days 70 It less than one day hrs. min.

9. Birthplace Waldorf Md  
(Town, county, and state)  
10. Usual occupation Farmer  
11. Industry or business Retired  
12. Name Richard Sanders  
13. Birthplace Ches Co  
14. Maiden name Anderson  
15. Birthplace Ches Co Md

16. Informant Sarah Elizabeth Sanders  
Address 7110-Accutson Rd SE Wash DC  
17. Burial Date thereof 2-27-51  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory St Paul Priory  
Location Accutson Md  
18. Funeral director H. Smith & Son  
Address Waldorf Md  
19. 2/26/51 19 Julia H. Pease  
(Date rec'd by registrar) Registrar Carroll Campbell

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 19 51 at 8:30 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 49 to Feb 19 51  
and that I last saw him alive on Feb. 24 19 51  
Immediate cause of death Uremia - 1 week  
Due to Cerebral Thrombosis 19 51  
Due to Arteriosclerotic Cardiovascular disease  
Other conditions Cellulitis of jaw  
4221 (Include pregnancy within 8 months of death)  
932 Major findings of operations none  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, till in the following:  
Accident, suicide, or homicide. Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE John P. Angelom  
M. D. or other  
Address 4223 Silver Hill Rd Date signed 2-25-51  
Silver Hill, Md. 290116

REC'D  
FEB 27 1951  
BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 1782 2032

## 1. PLACE OF DEATH:

County Prince George's CountyCity or town Upper Marlboro  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prince George'sCity or town Upper Marlboro  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2432  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Leroy Satawhite

## 3.(b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 30, 1917

8. AGE:

Years

Months

Days

If less than one day

33

hrs. min.

9. Birthplace Upper Marlboro, Md.  
(Town, county, and state)10. Usual occupation Laborer11. Industry or business Pool Room12. Name John Satawhite

13. Birthplace

14. Maiden name Ada Florence Gant

15. Birthplace

16. Informant Preston SatawhiteAddress Upper Marlboro, Md.

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location W. Ernest Jones Co. Inc.

18. Funeral director

Address 2432 York St. Balt.

19.

(Date rec'd by registrar)

19 51

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 19 51 at 6:00 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 15 19 51 to Feb. 13 19 51  
and that I last saw him/her alive on Feb. 12 19 51

Immediate cause of death

Pulmonary Tuberculosis

DURATION

1 year

Due to

Due to

Other conditions

Secondary Anemia2 months

(Include pregnancy within 8 months of death)

Major findings of operations

noneDate of op. —

Autopsy results

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James B. Sasser

M. D. or other

Address

Upper Marlboro, Md.

Date signed

2-13-51

990 858

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition  
in #7 shown on:

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FILE No. G 151 MAR 7 1951

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (Rural) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Sanatorium				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE D. C. COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) Washington TOWN STREET ADDRESS (If rural, give location) 721 7th St., S. E.			
3. NAME OF DECEASED (Type or Print) BLANCHE I. SIMEON		4. DATE OF DEATH (Month) Feb (Day) 28 (Year) 1951		5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 3-4-1911		9. AGE last birthday 39 yrs.		10. AGE last birthday If under 1 year Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John Parnell				14. MOTHER'S MAIDEN NAME Maude Jackson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. 577-14-0745		17. INFORMANT AND ADDRESS Decedent			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Pulmonary Tuberculosis						11 months	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) SUICIDE HOMICIDE				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work Not While At work		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 16 <sup>th</sup> , 1950, to July 28 <sup>th</sup> , 1951, that I last saw the deceased alive on July 28 <sup>th</sup> , 1951, and that death occurred at 8:42 P. M., from the causes and on the date stated above.							
SIGNATURE Daniel Leo Pinucane M.D.				ADDRESS Glenn Dale Sanatorium Glenn Dale, Maryland		DATE SIGNED 2/28/51	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF 3/1/51		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State) Washington, D. C.	
DATE REC'D BY LOCAL REG. 3/1/51		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS W. H. Chambers 577-11-16 Wash D.C.	



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>same</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Forest Heights</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Forest Heights, MD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>124 HURON DRIVE</u>	
3. NAME OF DECEASED (Type or Print) <u>WARREN E. SMITH JR.</u>		4. DATE OF DEATH <u>Feb. 28</u> 19 <u>51</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>Apr. 30, 1949</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>WARREN E. SMITH JR.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Father - above address</u>			

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Epilepsy  
Antecedent cause(s) (b) 353.3  
85  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH  
16 mos

### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office hldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)  
SUICIDE HOMICIDE INJURY  
TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7.28, 1950, to Feb 20, 1951, that I last saw the deceased alive on Feb 20, 1951, and that death occurred at 730 A.m., from the causes and on the date stated above.

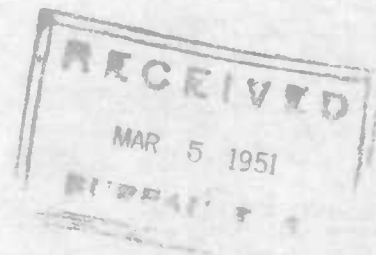
SIGNATURE (Degree or title) ADDRESS DATE SIGNED  
Morris J. Michael M.D. 3520 Cumberland St. NW. 2.28.51

23. BURIAL, CREMATION REMOVAL (Specify) DATE NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)  
BURIAL 2 MAR 51 ARLINGTON NATIONAL CEMETERY VIRGINIA  
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS  
Feb 28 Howard J. Beall J. WILLIAM LEE SONS CO. 300 4TH ST. N.E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Pr. George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
TOWN <u>Prince George Cy.</u>		TOWN <u>Hyattsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George Cy.</u>		STREET ADDRESS (If rural give location) <u>5504 Quincy St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u>	(Middle) <u>Percy</u>	(Last) <u>Smith</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>18</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Buffer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>	8. DATE OF BIRTH <u>4/13/1910</u>	9. AGE (last birthday) <u>40</u> yrs. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
13. FATHER'S NAME <u>Aguilla Smith</u>	14. MOTHER'S MAIDEN NAME <u>Martha E. Pyles</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>	16. SOCIAL SECURITY NO. <u>  </u>	17. INFORMANT <u>Mrs Dorothy S. Sparta, (Sister)</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
453.1 Immediate cause (a) <u>Multiple arterial thromboses</u>		
Antecedent cause(s) (b) <u>Buerger's disease</u>		
99 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>  </u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death		
19a. DATE OF OPERATION <u>1-19-50</u>	19b. MAJOR FINDINGS OF OPERATION <u>Arterial occlusion</u>	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>  </u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>  </u>	(CITY OR TOWN) <u>  </u> (COUNTY) <u>  </u> (STATE) <u>  </u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>  </u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>  </u>

22. I hereby certify that I attended the deceased from 12-19-50, to 2-18-51, that I last saw the deceased alive on 2-18-51, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

SIGNATURE J.P. Murphy MD ADDRESS 1904 R St NW DC DATE SIGNED 2-18-51

23. BURIAL, CREMATION REMOVAL (Specify)    DATE Feb 22, 1951 NAME OF CEMETERY OR CREMATORY Cedar Hill LOCATION (City, town, or county) Prince Geo. Cy., Md.

DATE REC'D BY LOCAL REG. Feb-19-1951 REGISTRAR'S SIGNATURE Amanda Downey 24. FUNERAL DIRECTOR W.W. Chambers Co., 517-11th St. SE. ADDRESS Wash., D.C. 690816

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1786 239

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Pr. Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>619 10th Street</u>	
3. NAME OF DECEASED (First) <u>Nettie</u> (Middle) <u>Mary</u> (Last) <u>Stevens</u>	4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>5</u> (Year) <u>1951</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Oct 6, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>73</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Washington West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Emmanuel Martin Castle</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Elizabeth Baine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>                    </u>	
17. INFORMANT <u>Miss Lenora McDevitt</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
590x Immediate cause (a) <u>Acute glomerular nephritis</u>	10 days	
130 Antecedent cause(s) (b) <u>                    </u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>                    </u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>                    </u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>                    </u>	(CITY OR TOWN) <u>                    </u> (COUNTY) <u>                    </u> (STATE) <u>                    </u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>                    </u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>                    </u>

22. I hereby certify that I attended the deceased from Jan 24, 1951, to Feb 5, 1951, that I last saw the deceased alive on Feb 5, 1951, and that death occurred at 9:15 P. m., from the causes and on the date stated above.

SIGNATURE Robert S. McDevitt M.D. ADDRESS 402 Main St Laurel Md DATE SIGNED 2/6/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE Feb 8, 1951 NAME OF CEMETERY OR CREMATORY Trinity Hill Cemetery LOCATION (City, town, or county) Laurel, Maryland (State)                     

DATE REC'D BY LOCAL REG Feb 8-51 REGISTRAR'S SIGNATURE M. Brashear 24. FUNERAL DIRECTOR Dr. W. H. Randall ADDRESS Laurel Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED 12 JAN 1951

1951 JAN 12

1561  
JAN 6 1951  
RECEIVED

The correct age of #10, 13, 14, & 17 shown on:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of #10, 13, 14, & 17 shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY <u>Princes George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesedley</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>	
TOWN <u>Chesedley</u>		TOWN <u>Hillside</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George Gen.</u>		STREET ADDRESS (If rural, give location) <u>1105-53rd Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Daniel</u>	(Middle) <u>Sweeney</u>	(Last) <u>Sweeney</u>
4. DATE OF DEATH	(Month) <u>Feb</u>	(Day) <u>22</u>	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>16 Apr 1863</u>
9. AGE last birthday <u>87</u> yrs.	If under 1 year Months <u>8</u> Days <u>22</u>	If under 24 hrs. Hours <u>22</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Religious - Clergyman - Nazarene Church Maryland</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Sweeney</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Ward</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Sam Sweeney</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.0 Immediate cause (a) <u>Hy postatic pneumonia</u>		2 days	
Antecedent cause(s) (b) <u>arteriosclerotic heart disease</u>			
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>hypertension</u>		15 yrs	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>INJURY</u>	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.			
SIGNATURE <u>William Brown</u>		ADDRESS <u>6124 Central Ave, Capital Hts Md</u>	
DATE SIGNED <u>2/22/51</u>			
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2-24-51</u>	
NAME OF CEMETERY OR CREMATORY <u>HOLLYWOOD NAZARENE</u>		LOCATION (City, town, or county) (State) <u>ST. MARY'S CO. MD.</u>	
DATE REC'D BY LOCAL REG. <u>2/22/51</u>		REGISTRAR'S SIGNATURE <u>Amanda Sourey</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS - CO.</u>		ADDRESS <u>517-11th St. S.E.</u>	

009896

RECEIVED  
FEB 28 1951  
BUREAU A. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH: COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges</u>		STREET ADDRESS (If rural, give location) <u>5307-42 ave</u>	
3. NAME OF DECEASED (Type or Print) <u>ELIZABETH M. TAIT</u>		4. DATE OF DEATH (Month) <u>Jul</u> (Day) <u>9</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Mar 15, 1886</u>
9. AGE last birthday <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Francis A O'Brien</u>		14. MOTHER'S MAIDEN NAME <u>Annie Condon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Alexis O'Brien Hyattsville Md</u>			

### 18. MEDICAL CERTIFICATION

#### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) Acute Coronary Occlusion

##### Antecedent cause(s)

(b) Diabetes Mellitus

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

#### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☐

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-6, 1948, to 2-9, 1951, that I last saw the deceased

alive on 2-9, 1951, and that death occurred at — m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

#### 23. BURIAL, CREMATION REMOVAL (Specify)

#### DATE THEREOF

#### NAME OF CEMETERY OR CREMATORY

#### LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG 2/13/51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

1789

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE D. C. COUNTY -	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale (Rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Sanatorium		STREET ADDRESS (If rural, give location) 3542 Warder St., N. W. ✓	
3. NAME OF DECEASED (Type or Print) GEORGE W. TAYLOR		4. DATE OF DEATH (Month) (Day) (Year) Feb. 17. 1951	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12/25/1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Preacher		10b. KIND OF BUSINESS OR INDUSTRY -	9. AGE last birthday 62 yrs.
11. BIRTHPLACE (State or foreign country) Alexandria, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Taylor		14. MOTHER'S MAIDEN NAME Annie Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO -		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT AND ADDRESS Decedent			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Pulmonary Tuberculosis

24 hrs. 3 months

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 6, 1949, to Feb 17, 1951, that I last saw the deceased

alive on Feb 17, 1951, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Daniel L. P. Pincus

M. D.

Glenn Dale Sanatorium

Glenn Dale, Maryland

2/17/51

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR.

ADDRESS

2/18/51

Use Weiss

W. Ernest JARVIS CO.

1432 N. St. N.W.

Washington, D.C.

009896

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
FEB 28 1951  
BUREAU V. F.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 283

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>D. C.</u> COUNTY <u>-</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glenn Dale (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Sanatorium</u>		STREET ADDRESS (If rural, give location) <u>403 M. St., N. E.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>SALLY</u> (Middle) <u>ANN</u> (Last) <u>TAYLOR</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>28</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>2/26/1891</u>
9. AGE last birthday <u>57</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>
11. BIRTHPLACE (State or foreign country) <u>Camden, S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Green</u>		14. MOTHER'S MAIDEN NAME <u>Sue Green</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Decedent</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

9 yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

#### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE PLACE (Home, farm, factory, street, office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

#### 20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/17, 1950, to 2/28, 1951, that I last saw the deceased

alive on 2/27, 1951, and that death occurred at 5:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

Glenn Dale Sanatorium

DATE SIGNED

2/28/51

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3/1/51

W. E. Weiss

Eula Louise Stephens 1425 Md Ave N.E.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

RECEIVED

MAR 5 1951

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CAPITOL HTS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CAPITOL HTS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>806-60th Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>JESSICA GRAHAME THATCHER</u>		4. DATE OF DEATH <u>FEB 16 1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, (DIVORCED) (Specify) <u>UNKNOWN</u>	8. DATE OF BIRTH <u>MAY 24 ? 80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRAMATIC TEACHER THEATRE</u>		11. BIRTHPLACE (State or foreign country) <u>MOBILE ALA</u>	
13. FATHER'S NAME <u>DREW GRAHAME</u>		14. MOTHER'S MAIDEN NAME <u>ANN HOWELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Wm J. C. Harold</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
443x Immediate cause	(a) <u>Cerebral Hemorrhage</u>		<u>6 days</u>
93d Antecedent cause(s)	(b) <u>Hypertensive Heart Disease</u>		<u>10 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 10, 1951, to Feb 16, 1951, that I last saw the deceased alive on Feb 16, 1951, and that death occurred at 3:23 P. m., from the causes and on the date stated above.

SIGNATURE <u>William Brannin MD</u>	ADDRESS <u>6124 Central Ave Capitol Hts Md 20740</u>	DATE SIGNED <u>2/16/51</u>
23. REMOVAL (Specify) DATE <u>2-16-51</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	LOCATION (City, town, or county) (State) <u>Prince Georges Md</u>
DATE REC'D BY LOCAL REG. <u>Feb 16 - 1951</u>	REGISTRAR'S SIGNATURE <u>Carrie F. Campbell</u>	24. FUNERAL DIRECTOR <u>W. M. Chambers</u> ADDRESS

001857

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Jessica Grahame

Thatcher



Drew Grahame

Ann

Howell

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

1792

Reg. Dist. No. 232

1. PLACE OF DEATH COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>P. G.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ritchie</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ritchie</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7127 White House Road</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>James Edward</u> (Middle) (Last) <u>Tucker</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>12</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>2/9/90</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Well Digger</u>	9. AGE last birthday <u>61</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Tucker</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ida Sturgess</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mary M. Tucker - Ritchie, Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute congestive heart failure</u> Antecedent cause(s) (b) <u>Cardiovascular renal disease</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>James D. Boyd</u> (Degree or title)		ADDRESS <u>M. D. Forestville, Md.</u>		DATE SIGNED <u>2/12/51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>2/15/51</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	LOCATION (City, town, or county) <u>Fort Myer</u>	(State) <u>Virginia</u>
DATE REC'D BY LOCAL REG. <u>Feb 14, 1951</u>	REGISTRAR'S SIGNATURE <u>Robert Smith</u>	24. FUNERAL DIRECTOR <u>Ritchie Bros. Upper Marlboro, Md.</u>		

970246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED  
FEB 19 1951  
BUREAU A. P.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH - COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md.</u> COUNTY <u>Pr. Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Eugene</u> (Middle) <u>E</u> (Last) <u>Natton</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>10</u> (Year) <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>2-13-1874</u>
9. AGE last birthday <u>76</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Number</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Busk</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Joseph Natton</u>		14. MOTHER'S MAIDEN NAME <u>Martha Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>710</u>	
17. INFORMANT AND ADDRESS <u>Eugenia M. Carrs Laybrite</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-9-51</u>	
Antecedent cause(s) (b) <u>Hypertensive Heart Disease</u>		<u>1946</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Pneumonia</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-9</u> , 19 <u>51</u> , to <u>2-10</u> , 19 <u>51</u> ; that I last saw the deceased alive on <u>2-10</u> , 19 <u>51</u> , and that death occurred at <u>2 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>E. J. Laybrite</u>		ADDRESS <u>Accokeek Md</u> DATE SIGNED <u>2-12-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2/12/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Christ Episcopal</u>		LOCATION (City, town, or county) (State) <u>Md</u>	
DATE RECD BY LOCAL REG. <u>2/12/51</u>		REGISTRAR'S SIGNATURE <u>R. E. Smith</u>	
24. FUNERAL DIRECTOR <u>Harold H. Laybrite</u>		ADDRESS	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

290687

RECEIVED  
FEB 15 1961  
BUREAU A. A. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. *245*

1794

1. PLACE OF DEATH COUNTY <u>Prince George's County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince George's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hampshire Knoles Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>6514 Flander Drive</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hyattsville Maryland</u>		STREET ADDRESS (If rural give location) <u>Hampshire Knoles Hyattsville Maryland</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Clifford Earl Weyman</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 3, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>2/21/1925</u>
9. AGE last birthday <u>25</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student Karpel Dental Institution</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Richard Weyman</u>		14. MOTHER'S MAIDEN NAME <u>Alice Saker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY No. <u>578-38-0471</u>	
17. INFORMANT <u>Catherine Weyman Hyattsville Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Cerebral compression

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Cerebellar hemorrhage

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*John J. Maloney M.D. Dep. Med. Exam. Choverly Hyattsville Md. 2-7-51*

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BurialFeb 6, 1951Lind Memorial CemeteryLouistown Misslin Pa.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb 3, 1951James SeveryF. Gasch's SonsHyattsville, Md.

099 VVV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

1795

Reg. Dist. No. 242

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>P.G.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bradbury Heights</u> 1 year		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bradbury Heights</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5213 V Street SE.</u>		STREET ADDRESS (If rural, give location) <u>5213 V Street</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Louis</u> (Middle) <u>Edward</u> (Last) <u>White</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>1/10/07</u>
9. AGE last birthday <u>44</u> yrs.		10. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>industrial</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles White</u>		14. MOTHER'S MAIDEN NAME <u>Ann M. Ryan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>578-10-5657</u>	
17. INFORMANT AND ADDRESS <u>George F. White</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary occlusion</u>			
420.1 Antecedent cause(s) (b) <u>Cardiovascular renal disease</u>			
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>James J. Bond</u>		DATE SIGNED <u>2-8-51</u>	
23. RURAL, CREMATION REMOVAL (Specify) <u>Feb 10-1951</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
DATE REC'D BY LOCAL REG. <u>Feb 8-1951</u>		REGISTRAR'S SIGNATURE <u>Edna L. Gollins</u>	
24. FUNERAL DIRECTOR <u>Wm. H. Jones</u>		ADDRESS <u>2701-18th St NW Wash D.C.</u>	

390459

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

1796

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits, write nearest town) <u>RURAL</u> and LENGTH OF STAY (in this place) <u>Transient</u> TOWN <u>Wintwood</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>D.C.</u> COUNTY CITY (If outside corporate limits, write nearest town) <u>Washington</u> TOWN <u>Washington</u> STREET ADDRESS (If rural, give location) <u>215 - Morgan St., N.W.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Don</u> <u>Wilkins</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 18.</u> 19 <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6-22-1895</u>
9. AGE last birthday <u>53</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>into mechanics</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>La.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>426-34-2934</u>	
17. INFORMANT AND ADDRESS <u>Florence Alston - Friend</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary occlusion</u>			
131a Antecedent cause(s) (b) <u>Coronary sclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Cardiovascular renal disease</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>John J. Maloney, M.D.</u>		DATE SIGNED <u>Feb 20, 1951</u>	
23. BURIAL, CREMATION REMOVAL, (Specify) <u>Burial</u>		DATE THEREOF <u>Feb 20, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Wood Lawn Cem.</u>		LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>2/16/51 Mrs. Jas. Severe (Deputy)</u>		24. FUNERAL DIRECTOR <u>Maloney &amp; Schey, 424-R St. N.W.</u>	

556816 Wash. D.C.



RECEIVED  
FEB 19 1951  
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for changes in MARYLAND STATE DEPARTMENT OF HEALTH  
#8 & #9 shown on:

2411 N. Charles Street, Baltimore

1797  
No. G 131 FEB 28 1951 CERTIFICATE OF DEATH

Reg. Dist. No. 225

1. PLACE OF DEATH- COUNTY <b>PRINCE GEORGE</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MD.</b> COUNTY <b>PRINCE GEORGE</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>RIVERDALE</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>RIVERDALE</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>6203 43RD ST.</b>		STREET ADDRESS (If rural, give location) <b>6203 43RD ST.</b>	
3. NAME OF DECEASED (First) <b>NELLIE</b> (Middle) <b>ESTELLE</b> (Last) <b>WILTSEY</b>		4. DATE OF DEATH (Month) <b>FEB.</b> (Day) <b>11</b> (Year) <b>1951</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>JUNE 30, 1928</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRACTICAL NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NURSING</b>	9. AGE last birthday <b>67</b> yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <b>ONARGA, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DAVID LAYER</b>		14. MOTHER'S MAIDEN NAME <b>LUELLA BAKER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If year, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY No. <b>NONE</b>	
17. INFORMANT AND ADDRESS <b>PAUL F. WILTSEY, 6203 43RD ST., RIVERDALE, MD.</b>			

18. MEDICAL CERTIFICATION  
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <b>Uremia</b>	INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
192X Antecedent cause(s) (b) <b>Metastases of</b>	<b>6 mo.</b>
55e Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>Malignant melanoma, right eye</b>	<b>18 month</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION <b>June 49</b>	19b. MAJOR FINDINGS OF OPERATION <b>Malignant melanoma right eye</b>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **June**, 19**50**, to **Feb. 11**, 19**51**, that I last saw the deceased alive on **Feb. 11**, 19**51**, and that death occurred at **11:22 A.** m., from the causes and on the date stated above.

SIGNATURE **George W. Reeves M.D.** ADDRESS **1746-K St. N.W. Wash. D.C.** DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <b>Interment</b>	DATE <b>Feb. 12 1951</b>	NAME OF CEMETERY OR CREMATORY <b>Russell</b>	LOCATION (City, town, or county) (State) <b>Russell Iowa</b>
DATE REC'D BY LOCAL REG. <b>Feb 11 1951</b>	REGISTRAR'S SIGNATURE <b>James Severy</b>	24. FUNERAL DIRECTOR <b>The S.H. Hines Co.</b>	ADDRESS <b>2901 14th St. N.W. WASH. D.C.</b>

781826



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

Reg. Dist. No. *215*

1798

1. PLACE OF DEATH COUNTY <i>Prince Georges</i> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <i>Quantico</i> TOWN <i>Quantico</i> HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Selma Memorial Hosp.</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>New York</i> COUNTY <i>Brooklyn</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i> TOWN <i>Brooklyn</i> STREET ADDRESS <i>3124 Brighton 5th St.</i>	
3. NAME OF DECEASED (Type or Print) <i>Isadore</i> (First) <i>Wollins</i> (Last)		4. DATE OF DEATH <i>Feb - 12</i> (Month) <i>1957</i> (Year)	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>2-27-91</i>
9. AGE last birthday <i>59</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Businessman</i>	
11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Isaac Wollins</i>		14. MOTHER'S MAIDEN NAME <i>-</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY No. <i>?</i>	
17. INFORMANT AND ADDRESS <i>Hospital records</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <i>Hemorrhage &amp; shock</i>		
Antecedent cause(s) (b) <i>Laceration of lungs -</i>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Crushed chest -</i>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office, etc.) <i>Street</i> INJURY <i>While at work</i>	(CITY OR TOWN) <i>Near Mount Airy, Md.</i> (COUNTY) <i>Frederick</i> (STATE) <i>Md.</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>2-7-51 - 5:40 P.m.</i>	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i>Automobile collision</i>

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE *John W. Maloney, M.D., Dep. Med. Exam.* ADDRESS *Cherry Hill, Hyattsville, Md.* DATE SIGNED *2-12-51*

23. BURIAL, CREMATION, REMOVAL, etc. DATE THEREOF *2/13/51* NAME OF CEMETERY OR CREMATORY *New York City* LOCATION (City, town, or county) *New York* (State) *New York*

DATE REC'D BY LOCAL REG. *Feb 13, 1951* REGISTRAR'S SIGNATURE *James Sevey* 24. FUNERAL DIRECTOR *E. Pasche* ADDRESS *Hyattsville, Md.*

690 VVV

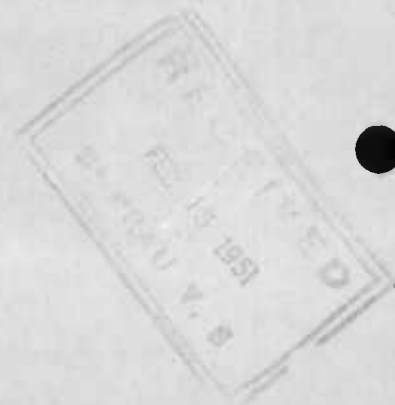
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

PRINCE

1870



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

1799

Reg. Dist. No. *245*

1. PLACE OF DEATH COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Pr. Geo.</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Mt. Rainier</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Mt. Rainier</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>3333 Buchanan St. Apt. 103</b>		STREET ADDRESS (If rural, give location) <b>3333 Buchanan St. Apt. 103</b>	
3. NAME OF DECEASED (Type or Print) <b>ELIZABETH LEA ZEIDERS</b>		4. DATE OF DEATH <b>February 6th, 1951</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>8/9/1914</b>
9. AGE last birthday <b>36</b> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Esterton, Penna.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>James E. Long</b>		14. MOTHER'S MAIDEN NAME <b>Edna Myers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT AND ADDRESS <b>Harry Zeiders, 3333 Buchanan St.</b>			

18. MEDICAL CERTIFICATION		19. Mt. Rainier, Md.	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <i>Gentle heart failure</i>		<i>Sudden</i>	
Antecedent cause(s) (b) <i>Arteriosclerosis</i>		<i>None</i>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Rheumatic heart disease</i>		<i>Chills</i>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <i>John Maloney, M.D. Dep. Med. Exam. Charles H. Hutton, M.D.</i>	DATE SIGNED <i>2-6-51</i>
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>Feb. 10/51</b>
NAME OF CEMETERY OR CREMATORY <b>Oberlin Cemetery</b>	LOCATION (City, town, or county) (State) <b>Oberlin, Dauphin, Cty. Pa.</b>
DATE REC'D BY LOCAL REG. <b>Feb 7 1951</b>	REGISTRAR'S SIGNATURE <i>James Sevey</i>
24. FUNERAL DIRECTOR <b>W.W. Chambers Company, Riverdale, Md</b>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

